Better Training Better Care (BTBC)
Pilot Site Evaluation Report

This report is designed to capture your pilot project in your own words. Each section should be completed in full, with appendices attached where necessary.

When completing the report, please adhere to the points below:
- Ensure that you complete each field provided.
- Ensure your answers are concise. Although there is no specific word count for each section, we are looking only for the relevant information to support wider adoption of your project. This report is intended to capture the fundamentals and the key outcomes of your project and should be succinct and easy to read, using plain English.
- Any toolkits, 'how to' guides or other resources that you feel are key to support the delivery of your project should be attached as appendices.

Please note that more detailed data and analysis of your project will be captured by our national evaluation partner Matrix Knowledge for them to independently assess.

Title
Please insert the title of your pilot and if applicable, a strapline to sum up the project in one sentence e.g.

Rapid Assessment and Treatment + (RAT+):

Safer, faster, quality care.

Introduction

The introduction should to summarise the background to the pilot intervention, what it set out to achieve and why.

Please note: A full and detailed summative report was submitted in addition to this case study report and it is advised that this should be read in conjunction with this report.

1. Background:

The Majors area of the Emergency Department (ED) presents a considerable challenge. Majors accounts for 49% of breaches (King's College Hospital data, source: electronic patient tracking system, Symphony) of the 4 hour standard (DH, 2010) and yet only 25% of all ED patients pass through the area.

Our Majors area continues to employ a 'triage and wait' approach, a system which has not changed for many years. There has been a succession of national reports in the last 2 years (Emergency Medicine Taskforce, 2012; NHS England, 2013, King's Fund, 2013) which emphasise the need for change and in particular, Rapid Assessment and Treatment (RAT) and the development of the Advanced Clinical Practitioner (ACP) role.

The RAT+ project was designed to formally test and develop both the RAT+ model and the Advanced Assessment Practitioner (AAP), the latter role as a stepping stone to full ACP qualification.

Following two early pilots in 2012 King's successfully secured support and funding from the Better Training, Better Care initiative from Health Education England. During the latter part of 2012 and through 2013 the RAT+ model was developed and piloted a further 3 times. In short the RAT+ model aims to:

- Improve (reduce) 'time to treatment' [Quality Indicator (QI) (DH, 2010)] for Majors patients.

- Improve (reduce) time to referral from arrival for Majors patients.

- Improve (reduce) total time in the ED.

- Improve (increase) supervision, education and learning opportunities for trainee clinical staff.

1.1 Rationale and drivers

Rationale:
The Majors area accounts for almost half of all breaches of the 4 hour standard and yet only 25% of all patients attending the ED will pass through it. In addition we recognised that the way patients were managed through that area had not changed significantly since the introduction of the 4 hour standard (DH, 2001) and arguably longer. Secondly is the work of

the Emergency Medicine Taskforce, established by the Department of Health in September 2011 to develop recommendations against the backdrop of poor ST4 fill rates in Emergency Medicine (September 2012). The Taskforce specifically recommended, in addition to other measures, expansion of the 'non-medical' workforce to include 'Advanced Clinical Practitioners' (ACPs).

Senior clinicians at King's shared a desire to change the way Majors functioned and this was coupled with a desire to develop the Advanced Clinical Practitioner role in emergency care. In addition we recognised an opportunity to develop a system where senior clinical input could be delivered at the beginning and end of the patient journey. This would not only improve patient care but, we believed, could enhance 'on the floor' supervision, education and training of our medical trainees.

Situation before the pilots:
At King's the Majors area employs a 'triage and wait' system. This ensures patients are assessed by an emergency nurse on arrival and allocated to the appropriate area within the ED. For those patients triaged to Majors they may be allocated to a cubicle or a chair, this is irrespective of mode of arrival (ambulance or self-presenting) and is based on the clinical assessment of need and acuity at triage. The patient then will wait to be seen by a doctor.

Whilst waiting the nursing and allied health professional staff can perform further assessment, initiate treatment such as analgesia and request a limited range of investigations such as blood tests. However, clinical decision making on definitive management and onward care cannot be carried out by these staff.

Patients will then be seen by a doctor who could be of any grade from foundation year 2 (FY2) through to a consultant. There is no specific allocation system and this process generally relies on whom ever if free to see the next patient in the 'queue'. Junior doctors, we know, will take more time to see a patient and make a decision about onward care.

Whilst we consistently ensure senior medical presence (ST4 or above) in the Majors area to support that process with the Junior medical staff it nevertheless takes time for them to seek that support. This effects the timelines and relative speed of that decision making which can impact on the overall journey time of the patient through the ED whether that be to discharge home of referral to an admitting team. Whilst the senior clinical input exists it can come late in the patient journey.

Local drivers/contextual factors:
We felt there was a not only a need to change the current system but that senior clinical input at the beginning of the patient journey would provide better, safer, care to patients. In addition, King's had already undertaken some preliminary work to develop the Advanced Assessment Practitioner role in Majors as a stepping stone towards developing an ACP workforce. These two drivers combined to develop the RAT+ concept.

What problems were you trying to solve?
Patients in the Majors area were consistently waiting more than 60 minutes to see a decision making clinician. This is more than the current DH (2010) A&E Clinical Quality Indicator (QI) for 'Time to Treatment' of <60 minutes.

Time to referral was felt to be a challenge in achieving the 4 hour standard when it exceeded 2 hours from arrival. Data suggested in Majors this was consistently approximately 3 hours.

Majors accounted for a disproportionate number of patients who breached the 4 hour standard. Whilst we and others recognise that the Majors patient cohort may always do so we nevertheless believed this could be improved.

2. Approach and engagement

2.1 Project development

Project development:
We initially piloted a RAT system in early 2012. These two pilots sought to 'test' the newly developed AAP role which would deliver RAT with support of senior clinical staff in the Majors area.

Following the first two pilots of January and February/March 2012 the data suggested that the development of a RAT system with AAP's could have a demonstrable impact on the 'time to treatment' and 'total time in ED' quality indicators. In addition, time to decision making/referral was also significantly reduced when compared to a control group. The result are summarised below:

Table 1: RAT pilots 1 & 2, January and February/March 2012 data:

Data expressed in minutes

	n =	Arrival – Time to treatment	Arrival – decision/referral	Time to treatment to decision/referral	Total time
RAT Means	42	53	113	62	220
non-RAT means	150	76	195	124	241
RAT median times	42	47.5 (Range 8 - 134)	111 (Range 29 - 228)	53 (Range 3 - 208)	202 (Range 106 - 713)
non- RAT median times	150	69 (Range 6 -206)	193 (Range 35 - 461)	105 (Range 1-333)	220.5 (Range 44 - 1755)

Although this data was promising we wished to develop the model further as we recognised there could be greater benefits from a team approach and in particular with consistent consultant presence as part of the RAT team, something we could not achieve during these two initial pilots. We therefore developed the RAT+ concept. There are two key differences from the traditional RAT model:

A team approach
The traditional RAT model proposes a sole clinician delivering RAT. RAT+ consists of a

consultant and an AAP establishing a team approach.

RAT+ places two consultants in the patient journey
One as part of the initial RAT+ team and the other working with trainee medical staff in the Majors area supporting their decision making, training and development. ED trainees indicated they would value greater input into their decision making processes, which RAT+ aims to support. The RAT+ model allows for greater Consultant supervision throughout the entire patient journey, not just at the end as was the case.

At this stage we learnt of the BTBC initiative and we submitted a bid for funding in which we were successful in April 2012.

Who was involved?
In the summer of 2012 we convened the RAT+ project group as follows:
- Robert Pinate, Consultant Nurse, Emergency Department – Project Lead.
- Dr Ed Glucksman, Clinical Director, Trauma, Emergency and Medicine (TEaM) – Project Senior Responsible Officer.
- Dr Malcolm Tunnicliff, ED Consultant and Clinical Lead.
- Dr Robiul Hoque, Emergency Medicine Consultant.

It should be noted that we also had support from senior clinical and managerial stakeholders within our Division and Executive team.

What were the aims and objectives of the pilots?
The objectives of the pilots were set out in the project initiation document (PID) as follows:

- It is anticipated that the majority of patients attending the Majors area of the ED will be initially assessed by a consultant and/or an AAP. This will allow the consultant to provide face to face guidance on the ongoing management of the ED patient to trainee doctors. At the same time the assessment and management skills of the AAP will be developed with the eventual aim of allowing them autonomous practice in the future. The RAT+ model we wish to develop has a separate consultant in Majors who will be able to reassess patients with the junior doctor to decide on either discharge or admission planning.

- This increased consultant supervision will have a significant impact on service delivery. The ED patient will be seen more quickly (thus freeing up space in the ED to see further patients). They will receive early consultant input to decide on management, followed by later consultant input to decide on disposition.

- Every moment will count. From the time of arrival to discharge a patient in the Majors area will be seen and reviewed by at least one, if not two consultants. As laboratory and imaging requests will be both expeditious and appropriate, time spent waiting for these results will be spent by the trainee gaining more in depth history and examination findings, whilst waiting final review by a consultant.

- ED trainees have indicated that they would value greater input into their decision making processes, something the RAT+ model aims to achieve. This allows much greater consultant supervision of the 'decision' making aspect of emergency care. Greater consultant supervision of trainees will lead to greater awareness of the

capabilities of these doctors. This will allow for better appraisal and development of those trainees.

The aims of the pilots were to:

- Improve (reduce) 'time to treatment' [Quality Indicator (QI) (DH, 2010)] for Majors patients.

- Improve (reduce) time to referral from arrival for Majors patients.

- Improve (reduce) total time in the ED.

- Improve (increase) supervision, education and learning opportunities for trainee clinical staff.

The pilots used quantitative and qualitative data to test the RAT+ model of care in the Majors area.

Working methodology:
The RAT+ team would see the next patient waiting to be seen in Majors. From the outset we knew not all patients in Majors would be seen by the RAT+ team as demand would outstrip the RAT+ team's capability during these pilot phases. Therefore, at the same time the current ED clinicians would continue to see patients. This then gave two groups; RAT+ vs. non-RAT at the same time and on the same day thus reducing, as far as practicable, issues of bias by avoiding the use of an historical control group.

The RAT+ team objective was to provide a brief assessment, prescribe treatment and institute a plan of care within 20 – 30 minutes of seeing the patient.

Quantitative outcome measures:
- Time from arrival to 'time to treatment' – RAT+ vs. non-RAT
- Time from arrival to decision (time to referral to an in-patient team or Clinical Decision Unit (CDU)) – RAT+ vs. non-RAT
- 'Time to treatment to decision/referral' - RAT+ vs. non-RAT. Provides a useful marker on the length of time clinicians are taking to make decisions for onward care.
- 'Total time' in the ED - RAT+ vs. non-RAT.

Qualitative outcome:
Through the use of online questionnaires in both the pre and post pilot phases of pilots 4 and 5 we sought to gather clinical staff feedback on the following themes:

- Medical trainees' perceptions of supervision, education and learning opportunities in the Majors area, with and without RAT+.
- Staff perception on the quality of care and the patient experience in the Majors area, with and without RAT+.
- Staff perceptions about flow and the amount of time they had to assess/care and treat patients in Majors, with and without RAT+.
- Overall perception of RAT+ post-pilot and its impact on patient safety.

What was the approach taken for delivering the training intervention(s)?
We did not set out to provide any specific training intervention; rather we sought to measure

the trainees perception of supervision, education and learning with and without RAT+ in place. Our hypothesis was that this would improve with RAT+ in place by virtue of the system proposed as opposed to a specific, targeted, intervention per se.

2.2 Engagement

Who did you need to engage in the pilot – for example: trainees, trainers, consultants, patients, executive board members?
As already described we had engaged and received support from the executive board, divisional leads, consultants in Emergency Medicine and the heads of nursing for trauma, emergency and urgent care.

Trainees proved a challenge for the project team and on reflection there were perhaps opportunities missed to fully engage with, in particular, the FY2 doctors. Whilst the project team did engage directly with our College of Emergency Medicine senior trainees and two of them were part of the project, the opportunities to meet as team were limited. This only occurred in pilots, 4 and 5 (January 2013 and July 2013 respectively) and this was late on in the entire project where we had an established approach to RAT+. The project team therefore met infrequently and on an ad-hoc basis which significantly reduced the opportunities to get our senior trainees involved. We should also acknowledge that there may have been other opportunities which were not fully realised or exploited.

What was the level of lay and patient involvement?
There was no lay or patient involvement with this project.

Did you get support from an academic partner to develop the evaluation and outcome measures?
Yes, this was key to the project. Dr Geraldine Lee, Lecturer & MSc in Advanced Practice Programme Lead, King's College London, provided invaluable support and assisted in undertaking all the quantitative statistical analysis. In addition, Dr Surinder Birring, Consultant Physician (Respiratory Medicine) King's College Hospital, assisted with the development of the qualitative questionnaires based on his experience of qualitative research in his field.

2.3 Project management and governance

The project team were primarily responsible for the design and delivery of the project. As both the Clinical Director for the Division (Dr Glucksman) and the ED Clinical Lead (Dr Tunnicliff) were both on the project team we also ensured we had a robust clinical governance approach.

The project team met on several occasions as the project progressed. This was particularly focussed during 2012 and early/mid 2013 when the model was still being refined and work was required to undertake the pilots themselves. Later on in the project, pilots 3, 4 and 5, meetings were much less frequent as the project and working arrangements were more established.

The project group also fed into the 'ED Core Group' weekly meetings which is part of our established governance framework in the ED.

In addition we provided BTBC with monthly project reports which included comprehensive updates and a risk register.

The project team delivered three RAT+ pilots in November 2012 (one week), January 2013 (two weeks) and July 2013 (two weeks). The gaps between pilots ensured we were able to fully evaluate the previous pilot and allow time to fully plan for the following pilot.

The project team produced the following key guidance documents:
- Rapid Assessment and Treatment (RAT) Team: A guide (see appendix 1)
- RAT proforma (see appendix 2)

Prior to a pilot the project team ensured:
- All ED staff were aware of the pilot period.
- Clinical rotas, both medical and nursing ensured consultant and AAP cover.
- Key stakeholders outside of the ED but with whom we interfaced with on a daily basis were aware of the pilot period.

During the pilots the project lead would:
- Where possible work directly with the RAT+ team providing guidance and support.
- Identify and record any issues arising out of the pilot.
- Note specific issues which would impact on the department as whole for the purposes of the reports which followed, such as lack of bed availability.

After each pilot the project team ensured/delivered:
- A detailed report of the pilot which included quantitative data analysis.
- The reports would be shared with BTBC and all the key King's stakeholders as outlined above.
- After the 5th pilot (July 2013) the project team published the summative report which included full quantitative statistical analysis and qualitative descriptive analysis.
- Ensure any costs derived from the project were accurately recorded and levied against the BTBC funding.

3. Resources

3.1 Funding

What funding did you bid for as part of your application and how much were you awarded?
The bid for funding was for £25,000. This was to ensure we could release the appropriate nursing clinical staff to deliver the AAP role.

What were the overall financial resources required to deliver your project? Please include the amount of trust funding required in addition to the BTBC funding.
The overall cost of the project was £96,728.80. This included all associated costs of the project which were not part of the BTBC funding (see appendix 3 for a full breakdown of costs).

It is important to note that the monies awarded to King's were used not only to release nursing staff. The cost of releasing staff was considerably less than anticipated. We therefore requested (to BTBC) that we utilise the funds to enhance the project in three aspects:

- The ability to ensure consultant presence on the RAT+ team during pilots 3 and 4 was proving very challenging given the demands of a busy ED. We also wished to ensure consultant cover for 8 hours a day for 10 days on pilot 5 which we recognised was simply not possible without specific additional shifts. We therefore opted to fund locum shifts for all our ED consultants at King's to provide 8.5 hours of clinical RAT+ cover for the 10 days of pilot 5. (see appendix 3 for a full breakdown).
- The development of the AAP role at King's was key to the project but we also recognised the broader educational requirements they would need to develop into full ACP's. We therefore requested permission from BTBC to use some of the funding to fund the first year of the Advanced Nurse Practitioner Masters degree programme at London South Bank University. This was a vital component in not only establishing the role but providing an educational and development pathway (see appendix 3).
- In pilot 4 only we also employed a locum Emergency Department Technician (EDT) to provide their support to the RAT team (see appendix 3).

The overall costs also included the effective costs of the key staff involved in the project, see appendix 3 for details.

What was the final budget amount at the end of your project?
£96,728.80 as detailed above and in appendix 3.

3.2 Staffing

What were the human resources required to deliver your project?
The human resources required can be summarised as follows:

Project team as detailed in section 2.1:
- Perhaps surprisingly was the amount of time required to deliver this project (see appendix 3 for a full breakdown). It is important to note that not only was the time required considerable but that given the nature of this project it required senior clinical leadership and input.
- In the project team we include the time given to the project by Dr Surinder Birring and Dr Geraldine Lee (see appendix 3).

RAT+ team:
During the pilots we required consultant cover and AAP cover. AAP's were all emergency nurse practitioners at band 7 or 8a grade. The nature of the pilots meant that the amount of time required of them differed from pilot to pilot:

Pilot 3:
- Consultants – 4 hours per day
- AAP's – 11 hours a day. This was borne out of the existing rota scheduling. The individuals did not necessarily spend the entire time delivering RAT+ on any given

day.

Pilot 4:
- Consultants – 4 hours per day (2 days were covered by an EM ST6).
- AAP's – 11 hours a day.
- Locum EDT – 11 hours a day.

Pilot 5:
- Consultants – 8.5 hours per day
- AAP's – 11 hours a day.

Additional resources:
Whilst not subject to formal costing we also had support from our finance lead who managed the budget. In addition we had direct input and support for the ED service manager.

3.3 Other key resources

Did you require any IT equipment or other types of equipment / specialist input?
Yes, we needed to be able to 'track' which patients had been seen by the RAT+ team versus those that had not on our Symphony (patient tracking) system. Our ED IT team therefore provided support in setting up unique logins for those clinicians delivering RAT+. This did not incur any additional cost from the BTBC funding.

Did you require any specialist medical devices or materials?
No

4. Achievements and outcomes

4.1 Overall achievements and critical success factors
What have been your greatest achievements and why?

Developing an evidence base for RAT+
To our knowledge, despite its widespread development, there is a lack of published evidence supporting the effectiveness and impact, or otherwise, of RAT. Whilst our project always sought to develop RAT+ and the team approach, it provides firm evidence as to the impact a RAT approach can deliver. It is hoped this generates further work in other centres fully exploring and examining the impact of RAT systems.

Establishing the AAP role
The ACP role is a significant step forward in the development of emergency nursing. Yet it continues to be seen in relatively few ED's. This project has shown what can be achieved by developing an intermediate, trainee role which departments can develop locally. This is coupled by the relative impact and effectiveness of that role by combining it with a RAT system which both supports the improvement of patient care but also the development of AAP's towards full ACP qualification.

What have been the critical success factors for enabling these achievements?
Institutional and individual commitment to the project has been critical to the success of this project. The project first started in October 2011 prior to being part of the BTBC initiative and has only recently completed with this final report. We have therefore had to sustain interest in and support of the project for two and a half years. That was made possible with the focused and committed hard work of key stakeholders and the project team.

Furthermore, the support from BTBC was an important driving force behind the project which allowed us to share and learn from the other projects in the initiative.

4.2 Delivered outcomes

Key outcomes

The overall key outcomes are:

Quantitative
Note: Both median and mean times are reported. The Department of Health's QI's utilises medians and so they are used here. Statistical analysis p values were derived from the independent samples *t*-test which utilises means.

- The RAT+ pilots included 765 patient episodes.

- 'Time to treatment':
  - RAT+ consistently achieved the 60 minute QI for Majors patients by reducing the median time to treatment to <60 minutes (median = 53 minutes) compared to the non-RAT group (median = 69 minutes)

  - The data supports the hypothesis that the RAT+ model reduced the time taken to being seen by a decision making clinician with an 18.3 minute (24.3%) reduction in mean 'time to treatment' when compared to the non-RAT control group. This is statistically significant, $p = <0.0001$.

- 'Time to referral'
  - RAT+ considerably reduced the median time to referral to in-patient teams from arrival (median = 105 minutes vs. 180 minutes).

  - The data supports the hypothesis that the RAT+ model would reduce the time to referral to in-patient teams from arrival with an 83.1 minute (43.6%) reduction in mean time when compared to the non-RAT control group. This is statistically significant, $p = <0.0001$.

- 'Total time'
  - RAT+ reduced the mean total time in the ED when compared to the non-RAT control group by 23.7 minutes (10%). This is statistically significant, $p = 0.013$.

  - This is repeated in pilot 5 alone which found a statistically significant reduction in total time of 26.7 minutes for the RAT+ group, $p = 0.046$.

- Evidence from pilot 5 suggests the RAT+ team discharged home approximately one

third of patients they saw in approximately 2 hours from arrival. This is considerably quicker than the non-RAT control group of approximately 3 hours.

Qualitative:
See full report for detail:

- The majority of medical (66.6%) and nursing (60%) staff reported that RAT+ improves the quality of care.

- Medical and nursing staff reported an improvement in patient experience with RAT+.

- The majority (78.3%) of clinical staff agreed that RAT+ improved patient safety.

- Evidence shows the majority of medical and nursing staff agrees that RAT+ improved flow through Majors.

- However, analysis suggests that trainees did not agree that RAT+ enhanced their educational experience in the Majors area.

For trainees

Qualitative data show that clinical staff broadly support the development of RAT+ and reported improvements in flow, quality of care and the patient experience. However, whilst medical trainees reported that support from senior colleagues was good, they did not feel that RAT+ enhanced their educational experience. Further work is required to fully explore how we can maximise the educational experience of our trainees with a RAT+ model.

Whilst this latter finding was disappointing it perhaps also illustrates the complexity of measuring the true impact of the RAT+ system. We have maintained that one of the key aspects of the RAT+ model is the '+', i.e. the consultant who remains in Majors supporting clinical staff. It appears the impact of the '+' is either difficult to measure or not seen as one which enhances support, education and learning. We should also note that trainees were not part of the RAT+ team and perhaps even felt removed from it so as to deprive them from learning opportunities. There is clearly more work required to fully understand and develop the RAT+ model as a vehicle for improved education of our trainees.

For trainers

This project did not seek to implement a specific training intervention or training methodology. As such we did not seek to identify specifically what the trainers felt about the training component per se. Nevertheless we did include all clinical staff (medical and nursing) in the qualitative feedback. In brief we concluded:

Improving quality of care and the patient experience is firmly at the heart of emergency care development, not just RAT+. Without RAT+ we noted a stark difference between the nursing staff perception that largely rated quality and patient experience as 'average' or 'poor', compared to their medical counterparts who had a more positive view. However, post pilot questionnaires revealed that staff from both professional groups felt RAT+ had a positive impact on quality and patient experience and the numbers of responses rating them as 'excellent' also increased. This proved consistent for the majority of staff (60% nursing and 66% medical) 'agreeing' or 'strongly agreeing' that RAT+ improved the quality of care for patients in Majors.

With average daily attendances in the ED at around 370 per day, it is perhaps no surprise that flow and time to care are key areas of focus. Only 6% (2/33) of respondents rated flow

as 'good' pre pilot. This compares starkly with the post pilot responses where flow was rated as 'good' or 'excellent' by 61% (14/23) of the respondents and just 1 (4%) rating it as 'poor'. Furthermore, when asked whether they agreed it was the RAT+ model which improved flow, 70% (16/23) respondents 'agreed' or 'strongly agreed'. This qualitative assessment appears to be consistent with our quantitative findings and it is encouraging to note the staff felt this impact. Waiting times were also seen as having improved by the nursing staff pre and post pilot. However, individual assessment of the impact of RAT+ in terms of their time to care is perhaps less clear with broadly flat pre and post pilot responses.

Space, or lack of it, was not a specific part of the set questions and yet a significant number of 'free text' responses focused on this key issue which goes hand-in-hand with flow. It seems clear that staff feel the lack of space impacts on flow. In addition, we received responses which supported the idea of establishing a defined 'space' for RAT+.

Finally, we wished to gain staff perceptions on the overall RAT+ model and its impact on safety. In both medical and nursing staff we found >60% rated the RAT+ model overall as 'good' or 'excellent' and 78.3% of them 'agreed' or 'strongly agreed' that RAT+ improved patient safety.

For patients

Staff feedback, as discussed above, reflected their belief that RAT+ improved patient care, their experience and safety. In addition, we were able to demonstrate that the patient's journey time and the time taken to make decisions about their care were reduced. Whilst we did not seek to quantify if quicker was 'better' for the patient we firmly believe that ensuring senior bedside clinical assessment, early in the patient journey, can and does improve the quality of care delivered.

Across the wider MDT

The development and establishment of the AAP role has already been discussed but was a critical success to this project for the wider clinical team in Emergency Medicine.

With Acute Medicine being our single largest referral route for patients requiring input from in-patient teams, this project enhanced our working relationships as we discussed and developed this key working relationship vis-à-vis the RAT+ system. As a consequence, our Acute Medical colleagues piloted an 'MRAT' system, whereby the Acute Physician of the day would rapidly review ED referrals in the ED. In addition the Acute Medicine team are exploring the development of ACP's specifically to form part of the Acute Medicine pathway.

That provide value for money

The principal driver has been the improvement in the quality of care we provide for patients. Detailed financial evaluation has yet to be undertaken. In addition the true financial impact of RAT+ may be challenging to measure based on these pilots alone. Once RAT+ is an established working methodology in the ED it would clearly warrant a detailed cost/benefit analysis.

One financial aspect we have examined during the course of the project was the relative cost of the AAP's versus middle grade locums. The principle behind the development of AAP's is their eventual qualification as ACP's which is like an Emergency Medicine middle grade (CT3/ST4). This is seen as part of the solution to broadening the clinical workforce

capable of seeing patients in the Majors area of an ED set against the backdrop of poor ST4 Emergency Medicine fill rates in recent years. This gap has necessitated increased locum medical usage and its associated costs. In short we compared the cost of an AAP vs. locum middle grade (clinical fellow level) cover, 11 hours per day, seven days a week:

Locum costs = £329,433 per annum

Band 7 AAP whole time equivalent requirement = 2.5 (includes uplift at 22%)
Substantive cost = £153,322 per annum

We can see therefore that the AAP role could provide a significant saving over their locum middle grade counterparts and provide a significant contribution to the clinical workforce assessing patients in Majors.

5. Experienced challenges

Key challenges
Staffing the RAT+ team; our greatest challenge during the pilot phases:

Consultant RAT+ team cover
As already described, from the outset RAT+ was predicated on a team approach with EM consultants being an essential part of that team. In the early pilots (1 and 2) prior to BTBC involvement we did not succeed in ensuring a consultant was part of the RAT process due to the constraints and challenges of an already stretched team.

In pilots 3 and 4 we were able to provide 4 hours of cover per day but this was only possible by consultants using their supporting professional activities (SPA) time to provide that cover. We recognised this would not be a sustainable solution but for the purposes of the pilots was the only way forward at that stage.

It is important to note that in pilot 4 we utilised an EM SpR (ST6) to provide RAT+ cover for 2 of the days. This was a deliberate part of the pilot to involve our senior trainees who can provide RAT+ cover which, we felt, should be part of higher EM training.

Given these difficulties pilot 5 differed in that we offered locum consultant shifts (8.5 hours per day) to cover the RAT+ 'rota' of 10 days over two weeks. We specifically wanted to see if having a dedicated consultant, with no other commitments on the day, for 8.5 hours would enable RAT+ to be successful. Pilot 5 results are very encouraging and we are now working towards replicating that model to establish RAT+ in the ED.

AAP cover
First and foremost we needed to identify those individuals who were appropriately trained and experienced to carry out this role. Appendix 1 contains an outline of the criteria we applied to select those suitable to carry out the role. We identified staff from our existing staff and all of them were already qualified Emergency Nurse Practitioners (ENPs) capable of seeing, assessing and treating minor injuries and illness'.

The BTBC funding was used to ensure we could provide locum backfill for any gaps created on the ENP rota as a result of the pilots. The financial impact of the pilots on ENP rota cover was less than predicted, partly due to the timing of the pilot phases which were not affected by increased staff leave. To that end we were able to release staff on many occasions without requiring backfill (see appendix 3 for a full breakdown). This also gave us the opportunity to utilise the funds in other ways to support the project as detailed in section 3.1.

Space/dedicated area
Throughout all the pilots the RAT+ team worked within the existing confines of the Majors area. We could not set aside any specific area or create a new area where the RAT+ team could focus their activity. Many ED's have developed specific areas for rapid initial assessment, our experience suggests that this is desirable given that the RAT+ team, at times, struggled to work effectively without a dedicated space. Our aim is to establish a RAT+ area as part of the overall strategy to embed RAT+.

Engagement with trainees
As already discussed engagement with trainees was challenging. Given the nature of medical training rotations it was particularly difficult given the project ran for two and half years. Challenges and what we did to overcome them are described below split into 'senior' and 'junior' trainees:

Senior trainees - ST4+
Senior trainees have longer rotational periods (up to a year) which enabled us to engage with individuals. However, as detailed in section 2.2 above, this didn't occur until relatively late in the project (pilots 4 and 5) where the vast majority of the design phase had already been undertaken. Nevertheless, senior trainees were able to feedback to the project group and one ST6 undertook two days of RAT+ cover.

Junior trainees - FY2
FY2's rotate every 4 months at King's. The project team were acutely aware that in order to obtain meaningful feedback (qualitative feedback pre- and post-pilot) any of the pilots and questionnaires would have to occur within that 4 month window. This also had to be set against the needs of the department, staffing and so on. Given this we only rolled out the qualitative questionnaires in pilot 4 where the response rate from the FY2's was low (33.3% pre pilot and 8.3% post pilot). In pilot 5 we therefore specifically engaged with the FY2 cohort (a new cohort from pilot 4) in their weekly teaching sessions, by email and face-to-face meetings prior to the pilot. However the response rate was far poorer (8.3% pre pilot and 0% post pilot). We believe this may have been due to running the pilot in July which ended just two weeks prior to rotation in August.

Rotas
Nursing rotas are generally written 2 - 3 months in advance whereas consultant rotas were as little as 4 - 6 weeks at the time. This meant that once a date had been set on the nursing rota it was imperative to ensure any subsequent medical rotas matched up with the pilot requirements. Whilst a minor challenge it served to emphasise the importance of having senior medical and nursing buy in to the project. Given the constant difficulties in medical

and nursing cover provision faced by many ED's this should not be underestimated.

6. Lessons learnt and recommendations

6.1 Lessons learnt

Other than the above challenges, what have you learnt through your experience of designing and implementing the project?

- Multidisciplinary input, buy in and support are essential.
- The trust as a whole has to support the initiative and accept the potential risks to 'normal' service provision during the pilot phases, i.e. the possible short-term effect of clinical cover.
- Input from experts outside of the ED was vital, for instance our Acute Medicine, academic colleagues and input from King's College London.

Were there additional benefits realised that were not originally identified at the start of the project? E.g. knock on impacts to other members of staff who were originally not targeted; greater collaboration across teams; and/or a financial gain which was not originally in the plan.
When we set out to develop the RAT+ model many focused on the patient admission pathway and how it may expedite that journey. However, pilot 5 provided clear evidence that a RAT+ approach can pay significant dividends for patients who could be managed and discharged home. With senior clinical input early in the patient journey and a model which was becoming refined and established, we saw an increasing number of patients seen by the RAT+ team were discharged home, 9% in pilot 4 rising to 31% in pilot 5. In addition, the median time to discharge was 123 minutes versus non-RAT patient's median time of 188 minutes.

If you were to undertake a similar project, what would you do differently?
Trainee engagement was the one significant area we did not feel we successfully achieved. Were we to undertake such a project again there would be some key actions we would focus on:
- Ensure trainees are aware of the project at induction, particularly for FY2's.
- Use the established ED teaching programme for all medical staff to engage with the trainees.
- Ensure trainee representation on the project group.
- Plan to run a pilot midway through the trainee rotation. This would ensure meaningful feedback pre pilot and allow sufficient time to gather feedback post pilot.

6.2 Recommendations – project enablers

What recommendations can you provide to other NHS trusts who may want to adopt your project? Please think about the critical 'enablers' that need to be in place to ensure the success of the project.

Staffing
The key area of focus has to be who is going to deliver RAT+. At King's we made a decision

that we did not want to reduce senior medical cover elsewhere to implement RAT+. In addition we specifically developed the AAP role to deliver a team approach. With this in mind trusts will have to examine:

- Consultant establishment and job plans to deliver a RAT+ model.
- Consider senior trainee/middle grade input which may be the best way forward for many organisations.
- Nursing establishment, leadership, educational requirements (see below for more detail).

AAP – ACP pathway

There is currently a national working group led by Health Education England examining the establishment of the ACP role in ED's. This work will provide essential detail into training, education (MSc pathways), competency assessment, mentorship and accreditation.

Our experience has shown that trusts need to consider:

Staffing

To establish 7 day a week AAP cover, as part of the RAT+ team, we chose to model that based on the current 11.0 hour ENP rota system. Thus in order to provide 7 day a week cover we would require 2.5 WTE at Band 7 (as detailed in section 4.2).

We developed a job description and person specification for the AAP role (see appendix 4) please note this is for a Band 7 AAP only, a more enhanced JD will be developed for the full ACP role in due course and is likely to be banded at 8a.

Educational pathway

AAP's are in essence trainee ACP's and they require a Master level advanced practice educational programme to qualify as ACP's. In general a full MSc programme will take 3 years. Our programme in London at London South Bank University is in the region of £2,500 per candidate, per annum. Many trusts will utilise their Health Education commissioning provision/allocation to support these pathways. However, this will be a new programme of education in a time where educational funding is decreasing so national and regional support is required to support trusts.

Staffing costs

Staffing cost as detailed in section 4.2 = £153,322. This is inclusive of inner-London weighting, uplift at 22%, at midpoint band 7.

Clinical leadership

A critical component of establishing advanced practice in an ED is ensuring there is senior, clinical nursing leadership to develop and support the AAP's. Those individuals should already be practicing at an advanced practice level; a nurse consultant post is extremely well suited to provide that level of leadership and support. Trusts must also ensure individuals are given the time and support to carry forward a significant workforce development project such as this. As an example the nurse consultant (project lead) at King's has spent approximately 0.3 WTE focusing solely on this project and the establishment of the AAP pathway.

Dedicated area

As discussed in section 5, our experience suggests that trusts should consider and provide a dedicated area for RAT+. This will need to take into account what the expected throughput will be and so detailed local modelling is required.

7. Sustainability and adoptability

What plans are in place to continue the project within your trust – please include details of wider trust rollout and/or spread to other specialties?

We are currently in the process of planning for a full rollout of RAT+ in the ED. There are three key areas under development:

- Development of a RAT+ area.
- Consultant job planning and establishment review to deliver RAT+ 8 hours a day 5 days a week initially, with a view to eventually providing 7 day a week cover.
- AAP establishment – achieved. A successful business case has established 2.5 WTE AAP's who commenced working in the Majors area in October 2013. Whilst the formal RAT+ system has not been fully established the four AAP's are gaining invaluable experience in seeing and managing patients in Majors whilst undertaking the MSc educational pathway, which commenced in September 2013.

Acute Medicine: colleagues have already completed an initial pilot of MRAT (see section 4.2 'Across the wider MDT'). Work is also underway to establish an Acute Medicine AAP role, which will work as part of the Acute Medicine take team.

How is the project being managed and by who?
The RAT+ project team continue to support and develop the RAT+ system led by the Nurse Consultant (Robert Pinate) and our EM Clinical Director (Dr Malcolm Tunnicliff).

What are the governance arrangements in place?
AAP's have a clear governance structure in place as set out in their job description (see appendix 4). In addition all AAP's have a consultant mentor with whom they meet on a monthly basis to support and monitor their clinical progress. We also discuss all trainees (medical and nursing) at the weekly consultants' meeting.

RAT+ has yet to commence but will be governed by an overarching RAT+ guideline, yet to be developed but akin to the RAT+ guide (appendix 1). We have an established weekly ED wide meeting (core group) and monthly this is given a specific focus on governance.

8. Feedback and testimonials

Please use this section to capture the feedback and testimonials you have received throughout the pilot project (where consent is given). This will be used for the final case study to support the engagement with and adoption by other trusts. You may include this as an appendix, weave the comments throughout the report or insert them in this section. Please state the title of the person concerned.

The vast majority of feedback was gained through the anonymised online questionnaire system used in pilots 4 and 5. Detailed analyses of the responses are given in the summative report.

Appendices:

1. Rapid Assessment and Treatment & the AAP role - a guide
2. RAT+ proforma
3. Costings spreadsheet
4. AAP Band 7 job description and person specification

King's College Hospital NHS Foundation Trust

Rapid Assessment and Treatment+ (RAT+) Team Guide

Background

Rapid Assessment and Treatment teams have existed in one form or another in UK ED's for some time. The principle idea behind RAT is to provide a team of senior clinicians to assess and implement a prompt care plan for major's patients. The intention is to make early senior decisions about patient care thus improving the quality of care and reducing the length of time in the ED.

It is clear that the Majors area requires improved flow, be it into the hospital or discharge, to put it simply there isn't enough capacity. We therefore need to find ways of improving the flow through majors and utilising in-patient resources effectively.

What follows is a 'how to' guide. It is principally intended to describe how the RAT+ team will function at King's ED. To that end it is not intended as a definitive guide and may change over time as we gain experience from the pilots.

Who is on the team?

The RAT+ team will comprise of:

- ED consultant.

- Advanced Assessment Practitioner – this role is defined in appendix 1 of this document.

- EDT.

How does it work?

Possibly the best way to describe its function is to follow the ideal patient journey:

1. Arrival and triage:

   Patients will be triaged as normal either at the triage area in the waiting room or ambulance triage.

2. Patient assigned a cubicle or sat on the chairs in majors.

3. RAT+ team – sees the patient within 30 minutes of arrival:

   - Click on the patient with your RAT+ login (this must be assigned separately by IT team).

   - Where the patient is on the chairs a cubicle space will have to be allocated.

   - It is not essential that ALL patients must be seen by the RAT+ team. We do not want to create another bottle neck with patients waiting to be seen by the RAT team.

4. RAT+ team review:

- The assessment should take approximately 15 - 20 minutes.

- It will include a brief history and physical exam. It is not a full clerking.

- The purpose is to decide:

  o What the likely diagnosis is.

  o What investigations are required?

  o What treatment should be initiated?

  o What the onward plan should be – there will be effectively 4 possible outcomes.

- Patient is referred to an in-patient team. This includes AAU.

- Patient is handed back to ED for further treatment. This is when the team decide a fuller assessment is required or that the patient could be managed entirely by ED.

- Patient referred to CDU utilising the CDU pathways. This may still necessitate a more in-depth assessment by ED before transfer to CDU.

- Patient discharged by RAT+ team.

- RAT+ team will complete the RAT+ proforma which will detail all of the above ensuring clear and concise documentation, see appendix 2.

5. What happens next?

- Where patients have been referred on to in-patient teams and/or AAU the patient should be transferred as soon as possible. This should not occur however before key investigations and treatments are initiated in ED.

- Patients handed back to ED. The nurse in charge will be informed and the card will be placed in the tray as usual. The patient will be 'referred' on Symphony so that it is clear the patient is for ED – in the 'Spec Req' column it will show as 'ED'. The Majors doctors will then see patients whilst referring to the RAT documentation.

- Patients for CDU may require more investigations and treatment in ED before transfer. Nevertheless the principle would be to transfer them to CDU as soon as practicable.

Frequently asked questions

RAT+ team members:

- Do I need to complete a full clerking?

No, the aim if for a focussed assessment and plan of care documented on the RAT proforma. Other clinicians further down the line will complete a more thorough assessment. Our aim is to reduce double clerking.

- Can I refer to AAU, other teams?

  Yes, there will be patients who will obviously require onward referral. The RAT+ team is empowered to make those referrals without the necessity of investigation results; this includes the AAP's.

- What if we can't see everybody who comes in to Majors?

  It is highly likely there will be times when it is simply impossible to see 'all' patients in majors. In these instances if a clinician in majors is ready to see the next patient they should, even if they haven't gone through the RAT+ team. We do not want to introduce delays with this process.

- What if I am not sure what to do?

  The RAT+ team is supported by an ED consultant specifically to provide advice. In the pilot phases and early in the project senior ED clinicians will be working side by side with the team members as the roles establish.

- What about 'stable' patients in resus?

  At the moment the RAT+ team is focussed on the Majors area only.

- Where do I document what I have done?

  We have developed a RAT+ team proforma (appendix 3) for documentation. We will use this in the pilot phase and again is subject to review and improvement.

Majors medical and nursing staff FAQ's

- Does this mean we won't see patients which require onward referral?

  No, there will be many patients who will require a more in-depth examination and history taking to facilitate decision making. In addition, as mentioned above, there will be times when the RAT+ team simply cannot see everyone.

  Also the RAT+ team will only be present during the day (10:00 - 18:30) and initially only 5 days a week. So you will still see patients who haven't passed through the RAT+ process.

- Do ED nurses still have to complete an assessment?

  Yes, the RAT+ team do not replace the necessity for a full nursing assessment. There are key aspects of the nursing assessments which are vital to providing high quality care.

- Who can refer to AAU and in-patient teams?

  Anyone on the RAT+ team can refer this includes the nurses acting in their AAP role.

Advanced Assessment Practitioner (AAP)

Background

Advanced nurse practitioner's (ANP's) are very clearly defined by the Nursing and Midwifery Council (NMC) and the Royal College of Nursing (RCN); and nurses must attain a high level of practice and have fulfilled an accredited educational programme. Nevertheless some nurses may already have the necessary skills and knowledge to be an ANP here at King's but to launch an ANP service from scratch is extremely difficult. We have therefore proposed to start with the RAT+ team model which facilitates the development of an AAP service. This will allow nurses to gain valuable experience working in majors as a practitioner and as such will provide a robust framework from which to develop a full ANP service in the future.

AAP definition

There is currently no national definition of an AAP; this is a term we created to distinguish it from an ANP. In order to facilitate a clear definition of an AAP and what they do a draft job description is currently being developed. We describe the AAP role as:

An Advanced Assessment Practitioner will practice within their sphere of competence and agreed acceptable limits of practice. Utilising advanced clinical skills the post holder will assess patients, order and interpret investigations, diagnose, treat, and refer patients who wish to be seen by an Advanced Assessment Practitioner without reference to a doctor in the 'majors' area of the department.

The role therefore is similar to an ENP role except an AAP cannot discharge patients home independently. The key aspect of 'discharge rights' in Majors will need considerable development and is tied in to the development of the ANP role.

In addition we are proposing that the AAP works exclusively as part of the RAT+ team initially in order to establish the RAT+ process and the concept of nurse practitioners working in the Majors area.

AAP knowledge and skills:

This will be detailed in the forthcoming job description and person specification. However we already know some key minimum levels of knowledge and skills necessary to practice as an AAP:

- 1st level registered nurse

- Degree level education in physical assessment/advanced assessment skills (or equivalent). The practitioner must be competent in all aspects of physical examination.

- Minimum of 5 years in emergency nursing.

These form the expected basic level. Clearly a significant aspect to practice as an AAP is experience not just simply the ability to examine a patient.

Banding/grade:

A draft job description is being developed with a view to having the job appropriately banded.

AAP role within RAT+

Your role is as a decision making clinician. You should follow the steps outlined above. As this is a new role there will clearly be times when it is difficult to make a decision or clinically the patient is complex. In order to support the development of the role there are two key support mechanisms:

- The consultant on the RAT+ team is there to provide advice and guidance to the AAP's. The consultants acknowledge this is a new role and so AAP will need developing.

- Rob Pinate will be working alongside all new AAP's to provide support on the 'floor'. As this is a new role we will be looking at what learning and development needs staff have as we go through the pilots to begin to outline an AAP development programme.

This is intended as a brief overview of the role only. Further development will come as a result of the pilot phases and detailed discussions with key stakeholders.

King's College Hospital NHS
NHS Foundation Trust

Appendix 2

Rapid Assessment and Treatment+ (RAT+) team proforma
King's Emergency Department

Name:	Dr/AAP:	
Hospital No:	Date:	
D.O.B	Time:	

PC & HPC:

Vital signs	Resp rate:	GCS:
	Pulse:	Temp:
	BP:	BM:
	Sats: FiO$_2$:	**POTTS:**

Examination:

Impression:

Treatment: (All drugs must be prescribed in the ED card)

Plan:

Disposition:	ED care: Resus	Majors	CDU	Minors
	Referral: AAU:		Time:	
	In-patient team:		Time:	
Signed:		Time:		

RAT proforma – V1.3 – Jan 2012 – Rob Pinate

Appendix 3

No.	Resource	Quantity	Band	WTE/FTE	Duration (in months)	Duration (in weeks)	Given Cost	Notes
1	Nurse Consultant - Project Lead	1	8b	0.3	0.3 WTE continuous for 18 Months Aug 2012 - Feb 2014	N/A	£34,948.50	Cost not applied to BTBC funding. This was part of the role as ED Nurse Consultant project lead. WTE is based on AFC T&C's with 0.2WTE = 7.5 hr. day
2	EM consultants on project board	3		N/A	Equivalent to 28 PA's over 18 Months Aug 2012 - Feb 2014	N/A	£23,255.12	Cost not applied to BTBC funding. From a trust standpoint the amount of 'time' given over to the project by the consultants is as shown.
3	AAP's locum backfill Pilots 3, 4 and 5	1	7		3 shifts (11 hrs. each) covered in pilot 3 only		£2,497.41	Costs have been applied only where we required backfill locum cover on the rota. Locum rates for SHO level medical cover. Pilots 4 and 5 did not require locum backfill
4	EM consultants - Locum cover. Pilot 5 only	16		N/A	N/A	10 days/2 weeks	£9,452.50	Only applies to those shifts funded from BTBC project monies in RAT+ pilot 5 - July 2013.
5	EM consultant - RAT+ shift cover during pilots 3 and 4	16		N/A	11 x PA's	N/A	£9,135.94	Cost not applied to BTBC funding. These were non-clinical PA's - used to provide clinical cover of the RAT+ pilots 3 and 4 only.

6	AAP's on shift for RAT+ during pilots 3, 4 and 5 NOT covered by locum use	N/A	7	N/A	N/A	18 shifts on pilots 3, 4 and 5	£5,293	AAP's on shift for RAT+ during pilots 3, 4 and 5 **not** covered by locum use = 18 days at 11hrs. per day, costed at mid-point Band 7
7	Emergency Department Technician						£1,377.92	Locum EDT cover only
8	Survey Monkey subscription	1	N/A	N/A	7	N/A	£511.13	Online survey portal used for the project
9	Consultant Respiratory Physician input for 8 hours approx./ 2 x PA's	1		N/A	N/A	N/A	£1,661.08	Cost not applied to BTBC funding. Time with project lead to develop questionnaires
10	Lecturer in Advanced Practice for 33 hours, approx., statistical analysis work	1	N/A	N/A	N/A	N/A	£1,036.20	Quantitative data analysis. Hourly cost = £31.40. The trust did not have to cover this cost, it is indicative of the cost of the lecturer's time
11	ANP MSc pathway at LSBU						£7,560	Cost for funding the MSC pathways for 3 AAP's.
12	Any other cost incurred?							
	Subtotal - BTBC funded only						**£21,398.96**	
	Grand total						**£96,728.80**	Includes the sub-total above

King's College Hospital **NHS**

NHS Foundation Trust

Emergency Department

Job description

TITLE: Advanced Assessment Practitioner (AAP)

GRADE: Band 7

DEPARTMENT: Emergency Department

DIVISION   Division of General and Emergency Medicine

REPORTS TO: ED Consultant Nurse

ACCOUNTABLE TO: Head of Nursing Emergency Department

The post holder must be a Registered Nurse (RN) (1) and bound by the NMC Code of Professional Conduct for Nurses, Midwives and Health Visitors. Particular emphasis is put at King's on the need to ensure that all staff recognises their responsibility to deliver services in a high quality, courteous, patient focused manner maintaining patient confidentiality at all times.

ROLE SPECIFICATION

The post holder will form part of the ED Nursing Team, working as an Advanced Assessment Practitioner (AAP). The post holder will share their skills and experience in the field of emergency nursing, management, professional development and research. The job is practically based, intended to ensure skills and knowledge are related to high quality care and efficient delivery of service. The post holder will also undertake projects at the discretion of the Care Group.

JOB SUMMARY

To practice as an Advanced Assessment Practitioner within own sphere of competence and agreed acceptable limits of practice. Utilising advanced clinical skills the post holder will assess patients, order and interpret investigations, diagnose, treat, and refer patients who wish to be seen by an Advanced Assessment Practitioner without reference to a doctor in the Majors area of the department. It is the intention of King's that the AAP shall form part of the Rapid Assessment and Treatment team on a day to day basis.

To be responsible for the assessment of care needs the development, implementation and evaluation of programmes of care, without supervision, and to teach other nursing and non-nursing staff. To take charge of the clinical area if necessary.

CLINICAL DUTIES

- Ensure that patients receive high quality clinical care including formulating a working medical diagnosis for patients presenting with undifferentiated urgent or emergency health care problems.
- Ordering and interpreting diagnostic tests.
- Ordering and interpreting radiological imaging which may include X-ray and ultrasound.
- Making referrals to other health care professionals.
- Prescribing medicines/ PGDs and treatments. Adhering to the policies regarding patient group direction.
- Ensure that effective discharge planning and health promotion is carried out.
- To monitor quality and continuity of patient care and ensure standards are met.
- Ensure accurate documentation of all care given.
- Establish and maintain effective communication with nursing, medical and paramedical colleagues to provide optimum patient care.
- Communicate effectively with patients, relatives, and colleagues.
- Participate in nursing audit, taking action to address improvements required.
- To provide expert nursing/ medical advice and support to patients, their families and other healthcare professionals following diagnosis and through treatment.
- To liaise with local community, social services, paramedics and voluntary organisations in order to develop existing services for clients, carers and health professional.
- To liaise with the patient flow coordinator, MDT and outside agencies to ensure appropriate and timely discharge/follow-up arrangement in place for patients.
- To actively involve service users in providing feedback of their experience of the current service and suggestions for improvements.
- To be competently skilled in roles associated with Major Incident & Decontamination
- To accurately identify those children and vulnerable adults at risk of abuse.

MANAGERIAL RESPONSIBILITIES

- Participate in the recruitment and orientation of new staff.
- Take appropriate action in managing incidents relating to violence/aggression within the department.
- Take appropriate action in dealing with situations that may result in a disciplinary action.
- Participate in the management and development of the clinical service within the Care Group.
- Participate in the investigation of adverse Incidents and Complaints.
- To play an integral role in the operational and strategic development of specialist service.
- Liaise effectively with all other disciplines within in the Trust and at local level.
- Initiate and participate in management of change to broaden activities, standards and communication links through the acute trust and primary care.
- To actively contribute to any relevant initiatives within the care group and provide support to senior colleagues and head of nursing.
- Act as an effective role model.

- To work with and support managers and clinical staff to identify areas where changes in practice are required.
- Ensure the formal reporting and recoding of adverse incidents in line with Trust policy.
- To support the Head of Nursing in implementing Trust initiatives and strategies.
- Network with the team of clinical nurse specialist within the Trust to evaluate, develop and promote the specialist-nursing role.
- To utilise and maintain information systems to aid required audit and to provide regular actively analysis reports.
- To maintain records and send reports (e.g. police reports) set by various bodies pertaining to the specific speciality.
- Maintain contemporaneous and accurate medical records, submitting relevant statistics, reports and activity data as requested. To evaluate the service in terms of clinical effectiveness, clinical excellence and value for money.
- To ensure the best use of available resources is used within agreed budget to provide a cost effective service.
- To forge effective links within primary secondary and tertiary care to ensure effective communication.

EDUCATION AND RESEARCH

- Maintain a learning environment and have an active teaching role.
- To contribute to the development of clinical practice within the team. Act as practice supervisor for nursing staff, other members of the MDT e.g. Emergency Care Practitioner's, Emergency Department Technicians, Doctors, students and other qualified nurses.
- Enable staff to develop and learn from their practice.
- Facilitate training for all members of the multidisciplinary team.
- Keep up to date with current ED and AAP practice and clinical developments.
- Take part in nursing research and audit within the department
- Participate in peer group, medical and other health professionals teaching.
- To provide information for clients, carers and heath professional about all aspects of specialist care.
- To ensure appropriate information and educational literature is available to help patients make informed choices as to their treatment plan and continuing management.
- To actively participate in education events provided by the Trust and primary care sector.
- To instigate, participate in and assist with any trust approved research projects conducted within the department.
- To promote nursing research and evidenced based practice relevant to the speciality.
- To work with and support department managers and clinical staff to identify areas where changes in practice are required. Also where opportunities exist for improving treatment and support of patients.
- Be proactive in developing the specialty of ED Nursing locally and nationally.
- To represent the department within the hospital and elsewhere as requested.

PERSONAL AND PROFESSIONAL DEVELOPMENT

- To achieve a range of clinical competencies as required within the Trust and Clinical Division.
- To keep up to date with current literature and research in the speciality.
- To maintain your own personal and professional development in accordance with PREP requirements, attending mandatory study sessions as required.
- To undergo and actively participate in your own performance appraisals
- To keep up to date with NMC, relevant specialist faculty & Trust guidelines and protocols.
- To adhere to the NMC Code of Professional conduct working within and accepting responsibility for maintaining agreed levels of competence.
- In carrying out the duties of the post, the employee is required to work in accordance with the policies and procedures of King's College Hospital, NHS Foundation Trust including Health and Safety, confidentiality, data protection and equal opportunities. King's College Hospital operates a no smoking policy.

KEY WORKING RELATIONSHIPS

- All ED Staff.
- GP's in ED
- On call teams and specialists
- Staff within the hospital wards and departments.
- Clinical Site Managers
- Community Services.
- Mental Health Services.
- Other 999 Service Providers, LAS, Fire, Police.
- Social services.

GENERAL

- The post holder has a general duty of care for their own health, safety and well-being and that of work colleagues, visitors and patients within the hospital, in addition to any specific risk management or clinical governance accountabilities associated with this post
- To observe the rules, policies, procedures and standards of King's College Hospital NHS Foundation Trust together with all relevant statutory and professional obligations.
- To observe and maintain strict confidentiality of personal information relating to patients and staff.
- To be responsible, with management support, for their own personal development and to actively contribute to the development of colleagues.
- This job description is intended as a guide to the general scope of duties and is not intended to be definitive or restrictive. It is expected that some of the duties will change over time and this description will be subject to review in consultation with the post holder.

- All employees must hold an 'nhs.net' email account which will be the Trust's formal route for email communication. You are therefore required to check this regularly and to deal with such communication promptly.

INFECTION CONTROL STATEMENT

- The post holder has an important responsibility for and contribution to make to infection control and must be familiar with the infection control and hygiene requirements of this role.
- These requirements are set out in the National Code of Practice on Infection Control and in local policies and procedures which will be made clear during your induction and subsequent refresher training. These standards must be strictly complied with at all times.

PERSON SPECIFICATION

Post: Advanced Assessment Practitioner

Grade: Band 7

Department: Emergency Department

Area	Essential	Desirable
Qualifications and experience including specialist knowledge and skills required	1st level registered nurse Degree level education and training in a recognised physical assessment / advanced assessment programme (or equivalent). Minimum of 5 years emergency nursing experience, within the last 10 years. Emergency nursing (or equivalent) post graduate study Mentorship qualification	Emergency nurse practitioner (ENP) qualification Independent and supplementary prescribing qualification ALS provider/instructor ATNC provider/instructor

Area	Essential	Desirable
Aptitude, abilities and characteristics	Strong clinical leadership skills and an effective role model High level of clinical acumen Able to prioritise Able to use own initiative Understand team nursing and team working. Eager to embrace change. Able to adapt to changing situations. Ability to think logically, to make decisions, copes with stress, and work with all levels of staff.	Interest in developing the AAP service Evidence of service improvement and change
Other skills		
Additional requirements	Able to work a variety of shifts as the needs of the service dictate Computer literate	